REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

914.1

THE IMPACT OF STAFFING SHORTAGES ON THE IDENTIFICATION AND RECOVERY OF MEDI-CAL OVERPAYMENTS

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March 5, 1980 914.1

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report on current staffing levels within the Medi-Cal overpayment identification and recovery system.

The Auditor General found that system staff reductions since the passage of Proposition 13 have hindered the identification and recovery of Medi-Cal overpayments. Specifically, cuts in the staffing of the hospital auditing function have caused the Medi-Cal program to forego the opportunity to recover overpayments of between $2.6 and $7 million annually. Further, staffing shortages have contributed to inefficiencies in other units responsible for the identification and recovery of Medi-Cal overpayments. Case backlogs in these units have caused delays in setting up collection cases and in conducting investigations. Consequently, the delays have reduced recoveries and have jeopardized successful prosecution of fraud.

The auditors are Richard C. Mahan, Audit Manager; Samuel D. Cochran; Ann Arneill; and Lisa A. Kenyon.

Respectfully submitted,

S. FLOYD MORI
Chairman, Joint Legislative
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SUMMARY

Medi-Cal is a $4.1 billion program, which is funded jointly by the State and the Federal Government. This program, authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code, provides health services to Medi-Cal eligibles and low-income Californians. An average of approximately 2.9 million persons qualify for services each month. Medi-Cal is administered by the Department of Health Services, which has a variety of responsibilities, including identifying and recovering Medi-Cal overpayments. An overpayment identification and recovery system administers this responsibility through the activities of seven primary program units. At a cost of $12.7 million, the system generated more than $58 million in recoveries during fiscal year 1978-79.

Our review disclosed that system staff reductions since the passage of Proposition 13 in June of 1978 have hindered the identification and the recovery of Medi-Cal overpayments. Specifically, cuts in the staffing of the hospital audit function have caused the Medi-Cal program to incur an annual opportunity cost of at least $2.6 million in net recoveries. In addition, we found that staffing shortages have contributed to inefficiencies in the operation of other system components. In three units, a substantial backlog of

cases has accumulated. This backlog has caused delays in setting up collection cases and in conducting investigations. Consequently, the delays have reduced recoveries and have jeopardized the successful prosecution of fraud. One unit has restricted its workload through a change in policy, but restricting workload means that potentially fraudulent activities are not investigated. While staffing shortages have contributed to causing these backlogs, workload management procedures may have contributed as well.

To address these problems, we recommend that the Department of Health Services provide the Legislature a report in time for hearings on the 1980-81 budget. This report should include (1) a plan for increasing the staffing of the hospital auditing function and (2) alternative staffing levels for other system components, including staffing costs as well as the effects of these levels on case backlogs, the length of time to complete a case, and the potential for increasing recoveries. In the final section of our report, we also suggest the Legislature consider increasing the staff of the Medi-Cal Fraud Unit.

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee, we have reviewed post-Proposition 13 staffing levels within the California Medical Assistance Program's (Medi-Cal's) overpayment identification and recovery system. We have also assessed the impact of these levels upon the system's ability to identify and recover overpayments. This review was conducted under the authority vested in the Auditor General by Section 10527 of the Government Code. It is the first of two reports examining Medi-Cal's overpayment identification and recovery system.

Medi-Cal is a $4.1 billion program which is jointly funded by the State and the Federal Government. This program pays for the health services received by Medi-Cal eligibles and low-income Californians. An average of approximately 2.9 million persons qualify for services each month. Known as Medicaid in other states, the program is authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code. For fiscal year 1979-80, the State's share of Medi-Cal expenditures is approximately 56 percent, and the federal share, 44 percent.

Medi-Cal beneficiaries are entitled to a variety of services rendered by professional health care providers. These services include outpatient visits to physicians' offices, dental services, drugs, inpatient and outpatient hospital services, nursing home care, and other health-related services.

The Department of Health Services (DHS) administers Medi-Cal through an agreement with the federal Department of Health, Education, and Welfare. The primary Medi-Cal responsibilities of DHS fall into three categories:

- Service provision--DHS operates the Medi-Cal fee-for-service program and administers and monitors prepaid health plans (PHPs), an alternative to the fee-for-service program.* DHS also procures and manages the contract with a fiscal intermediary (a nongovernmental agency) for reviewing and paying provider claims.**

- Standard and policy setting--The department develops and issues policies on Medi-Cal benefits, implements and monitors eligibility requirements, and develops the fee structure for the fee-for-service and PHP programs.

* In the fee-for-service program, providers of medical services charge a fee for each service rendered. In prepaid health plans, however, providers contract with the State to provide certain Medi-Cal beneficiaries necessary medical services for a prepaid per capita fee.

** The State does not directly pay physicians, hospitals, nursing homes, and other providers for the services rendered to Medi-Cal beneficiaries. Instead, it contracts with a fiscal intermediary. The fiscal intermediary function is being transferred from the Medi-Cal Intermediary Operations to the Computer Sciences Corporation.

- Program utilization controls--DHS exercises pre-payment and post-payment controls on Medi-Cal expenditures. Pre-payment controls include an authorization system prior to rendering medical services and a review system after services are delivered but before payment is made. The overpayment identification and recovery system provides the post-payment controls, those following payment of services.

The Overpayment Identification and Recovery System

Medi-Cal post-payment controls are exercised through the overpayment identification and recovery system, which is composed of seven primary program units. These are the system's three basic functions:

- Identifying potential overpayment cases from various sources, such as the fiscal intermediary's claims processing activities, county welfare departments' eligibility reviews, and beneficiary and provider complaints;
- Auditing and investigating potential overpayment cases;
- Collecting overpayments either by (1) having the fiscal intermediary deduct them from future provider claims or (2) by demanding direct repayment to the Medi-Cal program.

Units within the system include the Audits, Investigations, Medi-Cal Quality Control, and Surveillance and Utilization Review Branches of the DHS Audits and Investigations Division; the Recovery Section of the DHS Medi-Cal Division; the Medi-Cal Fraud Unit of the Department of Justice (DOJ); and the fiscal intermediary.*

Audits Branch

The Audits Branch identifies Medi-Cal overpayments to institutional providers, such as hospitals and nursing facilities. Staff perform fiscal and medical audits using provider cost reports, claims payment data from the fiscal intermediary, and medical records.

Investigations Branch

The Investigations Branch receives provider and beneficiary fraud complaints from a variety of sources. It investigates beneficiary fraud and provider civil and administrative cases from the conduct of a preliminary investigation to the final disposition of a case.** For provider criminal cases, the branch conducts only the preliminary investigation. Cases in which fraud is suspected are referred to the Medi-Cal Fraud Unit.

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* The State Controller's Medi-Cal Audit Project also audits some providers, but the overpayments it has identified have been relatively small. Its purpose is the assurance that integrity exists in the Medi-Cal payment system. Through delegation from DHS, it performs fiscal and management audits of providers, the fiscal intermediary function, and state Medi-Cal administrative units. Because of the project's independent oversight function in monitoring DHS, we did not include it in our review.

** DHS and the Attorney General's Medi-Cal Fraud Unit each interpret differently the definition of and responsibility for a preliminary investigation. Our discussion of responsibilities and activities of the Investigations Branch is based upon definitions used by the Department of Health Services.

Medi-Cal Quality Control Branch

The Medi-Cal Quality Control Branch estimates the amount of Medi-Cal dollars misspent annually. It reviews a statewide sample of claims, testing for proper eligibility determination, claims processing, and payment. It then refers cases to other system components.

Surveillance and Utilization Review Branch (SUR)

SUR identifies overutilization, abuse, and fraud by Medi-Cal beneficiaries and providers. It conducts claims and medical audits and then refers its findings and recommendations for disciplinary action to other system components.

Recovery Section

The Recovery Section identifies and collects Medi-Cal overpayments made for beneficiaries with other health insurance coverage and for those injured by liable third parties. The section also collects overpayments from providers and beneficiaries identified by other sources, such as county welfare departments, the Investigations Branch, SUR, and the Medi-Cal Fraud Unit.

Medi-Cal Fraud Unit (MCFU)

The MCFU investigates and prosecutes criminal violations by providers. It receives referrals from the DHS Investigations Branch.

Fiscal Intermediary

Although the fiscal intermediary's main function is to review and to pay provider Medi-Cal claims, it also identifies and recovers overpayments. It refers suspected fraudulent and abusive providers and beneficiaries to other units, like the SUR and Investigations Branches; provides them with payment history data; and, at the units' request, deducts identified overpayments from current provider claims.

Providers and beneficiaries can appeal overpayment demands. The DHS Office of Legal Services administers a two-level hearing process for provider appeals. Beneficiary appeals are heard by the Department of Social Services' Office of Public Inquiry and Response.

Scope of Review

We conducted a preliminary survey of the overpayment identification and recovery system. During this survey, we reviewed statutes and regulations governing system operations; objectives, methods, and resources of each component; and the interaction among components. We identified several areas of operation which could benefit from formal management review: the effects of staffing reductions, workload management practices, productivity measures, information sharing, and the impact of certain statutes and regulations on system operations. This report focuses on the impact of staffing reductions on the overpayment identification and recovery system. Our second report will address the remaining issues.

To analyze the fiscal impact of staffing reductions on the hospital auditing function of the Audits Branch, we reviewed the branch's auditing methods and analyzed past years' audit recovery performance. From this data we calculated the opportunity cost associated with staffing reductions since fiscal year 1978-79. Audits Branch management reviewed and concurred with our opportunity cost methodology.*

In reviewing the effects of staffing shortages on the operation of other system units, we (1) analyzed caseloads and workload management procedures at the five field offices of the Recovery Section, (2) reviewed caseloads and case screening procedures at the four field offices of the Investigations Branch, and (3) analyzed case backlogs and techniques for ranking cases at the Medi-Cal Fraud Unit headquarters in Sacramento.

* The opportunity cost represents monies which could have been collected had the staff in the Audits Branch not been reduced.

AUDIT RESULTS

SYSTEM STAFFING SHORTAGES HAVE HINDERED THE IDENTIFICATION AND RECOVERY OF MEDI-CAL OVERPAYMENTS

The overpayment identification and recovery system is cost beneficial; in fiscal year 1978-79, the system recovered more than $58.3 million at a cost of $12.7 million. However, post-Proposition 13 staffing shortages have hindered the system's ability to identify and recover Medi-Cal overpayments. Specifically, management of the Audits Branch has had to reduce its hospital auditing effort because of staffing cuts. As a result, this branch is incurring an annual opportunity cost of at least $2.6 million in net recoveries from these audits.

Staffing shortages have also contributed to hampering operations among other units of the overpayment identification and recovery system. In the Recovery Section's Compliance Unit, a backlog of overpayment collection referrals is increasing. Consequently, the unit has not collected approximately $1.6 million in Medi-Cal overpayments. Investigations Branch management has (1) developed restrictive screening criteria to manage an increasing preliminary investigation and case backlog and (2) delayed investigating

cases until existing staff become available. Because of these practices, the Investigations Branch is not investigating all beneficiary and provider fraud complaints it receives. Likewise, the Medi-Cal Fraud Unit has not worked many of the cases referred to it and has delayed working others until available staff can handle them. This unit, as a result, is not investigating all providers who may be perpetrating fraud. Essentially, the delays in working cases in both the Investigations Branch and the Medi-Cal Fraud Unit jeopardize the successful investigation and prosecution of fraudulent providers and beneficiaries because the quality of evidence and witness testimony deteriorates over time.

Even with additional staff, however, the system would not operate efficiently. Workload management practices of at least one component, the Compliance Unit, are deficient and need improvement. Additionally, other system components may have problems which impede efficient operation.

Background

Following the passage of Proposition 13 in June of 1978, the Governor and the Legislature acted to reduce state spending. The Governor issued Executive Order B-44-78 which restricted the hiring of new employees. Pursuant to this order, the Legislature instructed the Department of Finance in Section 27.2 of the Budget Act of 1978 to reduce the budget's General Fund appropriations by the equivalent of $54,000,000 in personal services. In May of 1979, the Department of Finance issued Management Memo 79-15 which continued the hiring freeze and directed all departments to rank their programs and eliminate their lowest priority programs equivalent to 10 percent of all appropriations. In Section 27.2 of the Budget Act of 1979, the Legislature instructed the Department of Finance to reduce the budget's General Fund appropriations by the equivalent of $25,224,000 in personal services.*

* The Department of Finance interpreted Section 27.2 as a permanent position and dollar reduction. However, with the passage of Chapter 1035, Statutes of 1979 (SB 186), the Legislature stated that the reduction was to be a one-time salary savings.

Consequently, the Department of Health Services had 200 new positions deleted from the fiscal year 1979-80 budget. The department also had to cut 200 existing positions. In determining which programs to cut, management of DHS elected to continue providing personal services to the public and providing for the public health.

Since the Medi-Cal overpayment identification and recovery system did not qualify as a protected function, DHS cut staffing in certain of its components. DHS management realized that cutting cost beneficial units would increase the cost of the Medi-Cal program. In a memorandum to the Department of Finance, the Assistant Director of DHS stated that "under this...approach, some prevention-oriented programs will be less effective and therefore, in the long run, our medical programs more costly." Additionally, in developing the state budget, the Legislature and the Governor have cut staff in the overpayment identification and recovery system.

The following table shows authorized and filled positions from fiscal year 1977-78 through fiscal year 1979-80 for system units affected by staffing shortages.

TABLE 1

STAFFING FOR FISCAL YEARS
1977-78 THROUGH 1979-80

Audits Branch	1977-78	1978-79	1979-80
Hospital Audit Function			
Fiscal Audits			
Budgeted Positions	82.0	68.0	75.0
Filled Positions	81.0	61.1	73.0
Multidisciplinary Audits			
Budgeted Positions	18.0	50.0	31.0
Filled Positions	18.0	44.6	30.8
Recovery Section			
Compliance Unit			
Budgeted Positions	30.5	34.5	34.5
Filled Positions	27.2	29.1	26.5
Investigations Branch			
Budgeted Positions	114.0	48.0	41.5
Filled Positions	113.0	48.0	40.0
Medi-Cal Fraud Unit			
Budgeted Positions	N/A	56.0	56.0
Filled Positions	N/A	44.3	54.2

Staffing for other system components has actually increased because some units have acquired additional responsibilities outside those areas affected by cuts. The Casualty Insurance Unit of the Recovery Section, for example, received 58 positions in fiscal year 1978-79 when it began assuming the third party liability collections previously made by Medi-Cal Intermediary Operations under the old fiscal

intermediary contract. Similarly, the SUR Branch acquired 33 positions to review claims previously examined by Medi-Cal Intermediary Operations.

Opportunity Exists to Recover at Least $2.6 Million Annually in Overpayments to Hospitals

Staffing cuts within the Audits Branch have reduced the number of field and multidisciplinary hospital audits and have increased the number of less comprehensive desk audits performed. As a result, the Medi-Cal program is neglecting an opportunity to make recoveries far in excess of salary savings from staffing cuts. Based on past performance, we estimated that the Audits Branch is incurring an annual opportunity cost of at least $2.6 million in net recoveries because of staff reductions in fiscal year 1978-79 and 1979-80.*

The Audits Branch is a highly cost beneficial operation. In fiscal year 1978-79, the branch produced more than $42 million in collections at a cost of $3.8 million. To identify overpayments to hospitals, the branch employs two different audit methodologies: fiscal audits and multidisciplinary audits. Fiscal audits consist of field

* Net recoveries are recoveries minus costs, including administration, supervision, auditors' salaries, and technical and clerical support.

audits and desk audits. During field audits, auditors examine source documents for annual cost reports and methods for accumulating and allocating costs. Desk audits entail reconciling the hospital's cost report with its financial statements and other supporting documents. These audits are less comprehensive than field audits and consequently do not generate as high a level of recovery.

Multidisciplinary audits, a new concept introduced in fiscal year 1977-78, include both fiscal and medical services audits.* These reviews are performed by teams consisting of auditors and medical professionals. Through multidisciplinary audits, the scope of the fiscal audit has been significantly modified and extended beyond that of field audits. The medical services audit has been designed to determine whether all medical services billed to and paid by the program were medically necessary and were provided in accordance with Medi-Cal regulations.

* The Audits Branch was required by the "Supplemental Report of the Conference Committee on the Budget Bill, Fiscal Year 1979-80" to issue a report on Project Cost-Watch (multidisciplinary audits) by January 1, 1980. However, that study had not been issued by the time our report went to print.

Reduction of Positions

In fiscal year 1978-79, the Audits Branch lost 14 fiscal auditor positions; this cut reduced its staff from 82 to 68. For that year it had also requested 20 additional positions to be funded by the Public Works Employment Act. These positions were to have expanded the branch's audit program to include noninstitutional providers. During the same budget cycle, the State Controller proposed its Medi-Cal Audit Project and requested a staff of 39. This project was staffed by diverting the 20 Public Works Employment Act positions requested by the Audits Branch and deleting an additional 19 hospital fiscal auditor, management, and support positions from the Audits Branch. The Governor subsequently vetoed funding for the 19 positions.* The positions, however, were not restored to the Audits Branch, although it did receive five support positions previously funded under temporary help provisions. The net effect was a reduction of 14 auditor positions.

In fiscal year 1979-80, the Audits Branch incurred an additional net loss of 12 positions. Within the fiscal audit function, the branch gained a net of 7 positions through the following actions: the Legislature restored funding for the 19

* According to the Legislative Analyst, the Governor vetoed these positions to avoid splitting the hospital auditing function between two state departments.

positions vetoed the previous year; the Governor then vetoed funds for 9 of them, and 3 positions were transferred to another unit. In addition, the multidisciplinary audit function lost 19 positions, 13 of which were fiscal and medical auditors. DHS eliminated 9 of these positions in accordance with Section 27.2, and the Legislature deleted the other 10 in the budget process. These restorations and reductions resulted in a net loss of 12 auditor and support positions to the branch's hospital audit function.

The loss of 14 auditor positions incurred in fiscal year 1978-79 was not affected by the restoration of 7 fiscal audit positions in fiscal year 1979-80. Branch management assigned eight auditor positions to other projects required by the Legislature. Six of these were assigned to a study of hospital contracts with pathologists, radiologists, and emergency room physicians. The other two were assigned to a review of wage increases in nursing facilities. The six positions remaining were simply not restored in fiscal year 1979-80.

Audit Regulations and Resulting Workload

The Audits Branch is required by law to audit all hospitals for each year they participate in the Medi-Cal program to determine the appropriate level of reimbursement. Furthermore, Medi-Cal regulations require that all cost reports

be audited within three years after they are submitted by the facility. To maximize net recoveries, the branch selects hospitals for field audit based on the level of Medi-Cal participation and past audit experience with the facility. Branch management stated that these criteria generally result in 75 percent of all the hospitals requiring field audits and the remaining 25 percent requiring desk audits. Yet, because of the pressure to complete a mandated workload with reduced manpower, management has downgraded the type of audit performed so that staff can conduct the required number of audits. Audits Branch management decided to escalate the number of desk audits and also to reduce their comprehensiveness. Table 2 below illustrates both the reduction in the number of field audits performed and the increase in less comprehensive desk audits performed.

TABLE 2

NUMBER AND TYPE OF HOSPITAL
AUDITS PERFORMED
AUDITS BRANCH
FISCAL YEARS 1977-78 TO 1978-79

Audit Type	1977-78	1978-79
Field Audits	271	206
Desk Audits	121	173
Multidisciplinary Audits	5	18
Total	397*	397

* The branch did not audit all hospital cost reports in fiscal year 1977-78 because it diverted auditors to complete work in other programs. Audit responsibility for the programs was to be transferred outside the branch.

As a result of this change in policy, auditors are now performing desk audits of cost reports which should be reviewed by field auditors. Moreover, despite the increased number of desk audits performed, the number of cost reports audited yearly is not keeping pace with the number of reports submitted annually by each of the State's 568 hospitals. The result is a growing backlog of cost reports. At the end of fiscal year 1978-79, this backlog amounted to 490 cost reports; it is expected to grow to approximately 540 by the end of fiscal year 1979-80. Audits Branch management stated that it may further limit the comprehensiveness of its desk audits to manage its workload. In addition, it will begin to accept certain cost reports as filed without performing desk audits.

Estimated Opportunity Costs

To determine the fiscal impact of the staffing cuts within the Audits Branch, we identified the opportunity costs associated with both the 14 auditor position reduction in fiscal year 1978-79 and the reduction of the 13 fiscal and medical auditor positions in multidisciplinary audits during fiscal year 1979-80. Our analysis was based on data detailing the productivity of hospital audits from past years and includes deductions for administrative overhead and disallowances for appeals.* This analysis was not intended to

* Providers can also appeal through civil procedures. However, we found few cases of provider civil appeals and still fewer which had been settled. Therefore, we did not include civil appeal disallowances in our analysis.

identify the extent of fraud and abuse within hospitals in the State but merely to indicate that opportunities for increasing recoveries exist. Branch management reviewed and concurred with our technique. Appendix A describes the assumptions and the methodology adopted in our analysis.

We estimate that the 14 field auditor positions cut in fiscal year 1978-79 could have generated more than $2.6 million in net recoveries to the Medi-Cal program.* Additionally, these recoveries, if collected, would have earned interest in the Pooled Money Investment Fund. Based on prevailing interest rates, we estimate this amount to be approximately $109,083.

Furthermore, the opportunity cost will be incurred each year that the 14 auditor positions are not restored and desk audits are performed in lieu of field audits. Thus, a similar opportunity cost will be incurred for fiscal year 1979-80. Should the eight auditor positions diverted to legislative projects be returned to field auditing after fiscal year 1979-80, an annual opportunity cost of $1.2 million associated with the six auditor positions not restored will remain.

* A percentage of recoveries approximating the extent of federal participation would revert to the Federal Government.

While fiscal year 1978-79 staffing reductions resulted in an estimated annual opportunity cost of over $2.6 million, additional fiscal year 1979-80 reductions in multidisciplinary audit staffing will augment this annual opportunity cost by up to $4.4 million. Thus, the combined annual opportunity cost may approach $7 million.*

Effect of the Common Audit Project

As part of a common audit project with the Medicare program, the Audits Branch has begun auditing a limited number of Medicare cost reports. The project calls for Medi-Cal auditors to audit hospitals' Medicare expenditures when conducting their field work. Similarly, Medicare auditors will audit Medi-Cal expenditures during their site visits. Eventually, responsibility for auditing the State's hospitals will be split so that hospitals will be subject to only one combined Medi-Cal and Medicare audit per year.

* Because the 80 hospitals audited were not randomly selected, the opportunity cost of multidisciplinary audits cannot be projected annually. Additionally, in calculating the $4.4 million multidisciplinary opportunity cost, we have considered disallowances for first level appeals only. Appendix A further describes the assumptions and methodology used in calculating the opportunity cost.

The common audit project will reduce by one-half the number of hospitals the Audits Branch must audit. Nonetheless, this project will neither alleviate the branch's staffing problems nor negate the opportunity cost we identified because it calls for field audits rather than desk audits. Also, the level of participation will be the major criterion for dividing the hospitals. Thus, the Audits Branch will assume responsibility for hospitals with the highest levels of Medi-Cal participation, and these require more audit time. Moreover, branch management estimates that a common audit will require 50 percent more field time.

Staffing Shortages Have Contributed to Inefficiencies Within Other System Components

Staffing shortages within other components of the Medi-Cal overpayment identification and recovery system have contributed to inefficiencies in their operation. In the Recovery Section's Compliance Unit, collection referrals have risen 61 percent since fiscal year 1977-78 while authorized positions have increased only 13 percent. The Investigations Branch has experienced a 63 percent reduction in authorized positions since fiscal year 1977-78. Likewise, the proposed number of positions for the Medi-Cal Fraud Unit was reduced by 41 percent. Case backlogs have accumulated within the three units. Consequently, delays in setting up collections and

investigating cases have resulted in reduced recoveries and have jeopardized successful fraud prosecutions. The Investigations Branch has adopted screening criteria to restrict its workload. But restricting the workload means that potentially fraudulent beneficiaries and providers are not investigated. While staffing shortages have contributed to causing these backlogs, workload management procedures may have contributed as well.

Compliance Unit

The Compliance Unit in the Recovery Section has significant problems managing its caseload. A backlog of 3,401 case referrals worth approximately $1.6 million has not been set up for collection. This problem can be partially attributed to the 61 percent increase in collection referrals over the last two fiscal years. Furthermore, while the workload has increased, the number of filled positions has declined.

The Recovery Section includes the Compliance Unit, the Casualty Insurance Unit, and the Health Insurance Unit. The Compliance Unit acts as a collection agency, receiving overpayment referrals, setting them up as collection cases, and taking steps to recover amounts due. The Casualty Insurance Unit identifies and collects Medi-Cal overpayments from liable

third parties (individuals and their casualty insurance companies) involved in injuries to beneficiaries. The Health Insurance Unit identifies and collects Medi-Cal overpayments from beneficiaries' health insurance carriers.

The Compliance Unit accounted for $2,561,012 of the section's $8,824,578 in recoveries during fiscal year 1978-79. Like the other two units, the Compliance Unit is cost beneficial. For every dollar expended, the unit recovers nearly three. It is the primary collector for some system components, including the Surveillance and Utilization Review and the Investigations Branches, and a secondary collector for others.*

These overpayment referrals which the unit receives have increased 61 percent during the past two fiscal years. As shown by the following table, the number of referrals has exceeded the unit's capacity to set them up as collection cases. Consequently, a backlog of 3,401 cases valued at approximately $1.6 million developed between July 1, 1977 and August 31, 1979.

* The fiscal intermediary is the primary collector for the Audits Branch.

TABLE 3

REFERRAL AND BACKLOG INCREASES
FROM FISCAL YEAR
1977-78 THROUGH AUGUST 1979

Fiscal Year	Number of Referrals Received	Number of Cases Set Up	Backlog
1977-78	4,797	4,733	64
1978-79	7,763*	4,810	2,953
1979-80 (July and August only)	1,341	957	384
Total Backlog			3,401

* The 7,763 referrals represent an increase of 61 percent over the previous year's 4,797 referrals.

According to the Compliance Unit chief, the referrals have increased for a number of reasons. Specifically, the sources of referrals have developed better techniques for processing information. In addition, the unit has developed a voluntary repayment category for certain beneficiaries exceeding their allowable property limits. Finally, the passage of Proposition 13 has reduced the beneficiary overpayment cases handled by counties; thus, these cases are now sent to the Compliance Unit.

Management of the Recovery Section stated that the backlog of referrals has hindered recoveries. They also noted that the potential for collecting overpayments of backlogged cases decreases over time because beneficiaries become difficult to locate and providers, such as nursing homes, may terminate operations.

The Compliance Unit's authorized staff increased 13 percent from 30.5 to 34.5 positions between fiscal years 1977-78 and 1978-79. However, despite the increased workload, the chief of the Recovery Section did not further increase staffing in the Compliance Unit because staff could not be spared from the other units. In fiscal year 1979-80, 9.9 positions in the Recovery Section were lost because of staffing cuts induced by Section 27.2 of the Budget Act of 1978. Another five positions were transferred within DHS as part of a departmental reorganization. Since DHS management had determined that 20 additional positions in the Recovery Section were being considered for elimination under Section 27.2, 18 of the 58 authorized Casualty Insurance Unit positions remained unfilled until October 1979. In addition, two Compliance Unit positions remained vacant.*

* The Region IX Medicaid Bureau of HEW's Health Care Financing Administration has also been concerned with Recovery Section staffing. In its September 10, 1979 Medicaid State Management Report, the bureau questions the reasonableness of the DHS Health Insurance recovery effort. It recommends DHS seek additional staff for this cost-beneficial function.

High staff turnover and the hiring freeze have compounded the Compliance Unit's staffing problem. Even though 4 authorized positions were added between fiscal years 1977-78 and 1978-79, the unit's 26.5 filled positions as of November 1, 1979 are actually fewer than the 27.2 filled positions in fiscal year 1977-78. The Compliance Unit chief stated that filling vacant positions is difficult because of the hiring freeze which prohibited hiring employees from outside state service. Even when current state employees are hired, the paperwork and the review procedures can take up to 15 weeks.

Factors besides staffing may be contributing to the backlog of overpayment referrals. During our staffing review, we found significant workload management problems in the unit's Southern Region. We found that regional offices were not adhering to the Compliance Unit's case follow-up procedures, and one office was setting up low priority referrals for collection prior to setting up those with higher priority. These problems will be discussed in our second report.

Investigations Branch

The Investigations Branch restricted its workload in fiscal year 1978-79 by screening each complaint according to its recovery potential before opening a preliminary investigation. Despite the reduction in workload resulting from this initial screening, the backlog of preliminary investigations and cases is increasing. Staffing reductions have contributed to this problem. Staffing in the Investigations Branch has dropped from a high of 114 in fiscal year 1977-78 to a low of 41.5 in fiscal year 1979-80, a 64 percent reduction.

The Investigations Branch handles beneficiary and provider fraud complaints, which it receives from sources such as the fiscal intermediary, county welfare departments, providers, beneficiaries, and other public agencies. The Investigations Branch has complete responsiblity for investigating beneficiary fraud complaints from the conduct of a preliminary investigation to the final disposition of a case. For provider fraud complaints, the Investigations Branch performs only the preliminary investigation and then refers these cases to the Medi-Cal Fraud Unit.

The Investigations Branch restricted its workload in fiscal year 1978-79 by initiating preliminary investigations only for those complaints with a recovery potential exceeding $750. Complaints with an estimated recovery potential under $750 are now referred to the Recovery Section for collection. As illustrated by Table 4, this screening policy has reduced the number of preliminary investigations and cases opened.

TABLE 4

WORKLOAD REDUCTION
INVESTIGATIONS BRANCH
FISCAL YEARS 1977-78 THROUGH 1978-79

	1977-78		1978-79	
	Provider	Beneficiary	Provider	Beneficiary
Preliminary Investigations				
Opened	5,440	9,007	3,693	5,853
Percent Change			-32%	-35%
Cases				
Opened	1,530	1,594	815	1,240
Percent Change			-47%*	-22%

* This reduction also reflects transferring the responsibility for investigating provider fraud cases from the Investigations Branch to the Medi-Cal Fraud Unit.

Despite attempts by the Investigations Branch to reduce its workload, the backlog of preliminary investigations and cases has increased between fiscal years 1977-78 and 1978-79, as depicted in Table 5.

TABLE 5

BACKLOG INCREASE
INVESTIGATIONS BRANCH
FISCAL YEARS 1977-78 THROUGH 1978-79*

	1977-78		1978-79	
	Provider	Beneficiary	Provider	Beneficiary
Preliminary Investigations				
Average Number on Hand at the End of the Month	1,287	1,644	1,241	2,181
Percent Change**			+9.9%	+19.0%
Authorized Staff	114	114	48	48
Number per Authorized Staff	11	14	26	45
Percent Change			+57.7%	+68.9%
Cases				
Average Number on Hand at the End of the Month	538	680	446	486
Percent Change***			+19.5%	-3.5%
Authorized Staff	114	114	48	48
Number per Authorized Staff	5	6	9	10
Percent Change			+44.4%	+40.0%

* Backlog was measured by computing for each year the average number of preliminary investigations and cases on hand at the end of each month.

** Computed as a percentage of preliminary investigations opened each year to equalize year-to-year changes in workload.

*** Computed as a percentage of cases opened to equalize year-to-year changes in workload.

Backlogs delay complaint and case investigations; these delays in turn jeopardize successful Medi-Cal fraud investigation. Investigations Branch management stated that ideally, beneficiary fraud cases should be completed without delay because beneficiaries perpetrating fraud tend to move frequently and cannot be located at a later date. Delays in investigating provider fraud also cause problems. Some providers have a high rate of turnover of office staff, and records are sometimes misplaced. Thus, reconstructing previous time periods can be difficult if investigations are delayed too long. For both types of cases, the quality of witness testimony deteriorates over time because of witnesses' memory loss. Delays in investigations can also create difficulties in locating witnesses.

Staffing reductions in the Investigations Branch over the last three fiscal years have contributed to these problems. In fiscal year 1977-78, the Investigations Branch had 114 budgeted positions. At the close of that fiscal year, it lost 59 positions: 32 CETA positions expired and 27 positions were transferred to the newly created MCFU. In fiscal year 1979-80, the branch lost nine more positions in accordance with the Governor's 10 percent reduction requirement. In the Investigations Branch, staffing has dropped from a high of 114 in fiscal year 1977-78 to a low of 41.5--a 64 percent reduction. Again, problems with workload management may also be reducing productivity in this branch.

Medi-Cal Fraud Unit

The Medi-Cal Fraud Unit has a significant problem processing its caseload, as evidenced by the increasing backlog of cases needing investigative work during fiscal year 1978-79. The current staffing level has contributed to this problem. Cases which go unworked for a year or more will probably never be investigated. Thus, providers who may be defrauding the program are not investigated. For case investigations delayed due to the backlog, successful prosecution is doubtful.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) authorized federal funds for staffing independent units to investigate and prosecute Medicaid fraud. This legislation funds 90 percent of California's expenditures through fiscal year 1980-81. The Medi-Cal Fraud Unit, located in the Office of the Attorney General, was certified as of July 1978. This unit, which investigates Medi-Cal fraud perpetrated by providers, receives referrals primarily from the DHS Investigations Branch. It also develops a limited number of its own cases.

To handle its excessive workload, MCFU has developed a system of ranking cases. Class 1 cases are those with the greatest potential for successful prosecution. The ranks extend down to Class 4, which applies to cases with no apparent criminal activity.

After receiving a case referral, unit staff will open the case, classify it according to the ranking system, and, depending upon the classification, may close the case immediately. As illustrated by Table 6, Class 3 and Class 4 cases are often not investigated, merely classified, then closed.

TABLE 6

UNWORKED CASE CLOSURE
BY CASE CLASSIFICATION
FISCAL YEAR 1978-79

	Number of Cases Opened	Number of Cases Closed	Number of Cases Closed Without Work	Percentage of Opened Cases Closed Without Work
Class 1	213	84	5	2.3
Class 2	191	13	13	6.8
Class 3	195	117	93	47.6
Class 4	109	106	102	93.6

A significant opportunity cost is incurred when cases are not investigated, particularly if they are Class 2 and 3 cases. Class 2 cases that cannot be assigned to investigators because they are working excessive caseloads are held for 12 months before they are returned to the Investigations Branch. Class 3 cases are held six months while Class 4 cases are returned immediately to DHS. As discussed in the preceding section, the Investigations Branch has problems handling its own workload. When MCFU cases are returned, they are added to the growing Investigations Branch backlog. Unfortunately, a

high percentage of returned cases over one-year-old are closed out by the Investigations Branch with no further work done. Thus, providers who may be defrauding the Medi-Cal program are not investigated.

For those cases being investigated, a significant backlog has developed, as shown in Table 7.

TABLE 7

BACKLOG INCREASE
BY CASE CLASSIFICATION
FISCAL YEAR 1978-79

	Backlog July 1978	Backlog June 1979	Backlog Increase	Percentage Increase in Backlog
Class 1	49	129	80	163.3
Class 2	41	178	137	334.1
Class 3	15	78	63	420.0
Class 4	3	5	2	66.7
Total	108	390	282	261.1

When backlogs develop, case investigation is delayed. Such delays have several harmful effects. First, a provider's potentially fraudulent activity continues during the period in which the case is not investigated. Furthermore, delays hold up administrative action, such as suspending or revoking the provider's number or license to practice, because all criminal investigation and prosecution must be completed first. Ultimately, delays jeopardize successful prosecution because the quality of evidence and witness testimony deteriorates over time.

The current staffing level contributes to the MCFU's inability to handle its workload. For fiscal year 1978-79, it had 56 authorized positions. That staffing level, however, is below the amount the unit felt necessary to do the job. It had requested 94.2 positions, which the Legislature reduced to 56 after having stated that workload data from DHS did not justify the need for all positions.

MCFU management believes that its current staffing level hinders its effectiveness. That opinion was shared by the Office of Program Integrity, U. S. Department of Health, Education, and Welfare, which found that the unit did not have sufficient investigators to handle the caseload.* The staffing level, however, may not be the sole cause of existing problems. Workload management problems may also be affecting operations.

CONCLUSION

Our review disclosed that staffing shortages within the Medi-Cal overpayment identification and recovery system have hindered the system's ability to function effectively. We found that staffing reductions within the hospital auditing function of the Audits Branch have resulted in an opportunity cost of at least $2.6 million annually. In addition, we found

* "Annual Report for 1978-79," California Medi-Cal Fraud Unit.

that staffing shortages have contributed to inefficiencies in the operation of other system components. However, other factors such as workload management procedures may also hinder system operation.

RECOMMENDATION

We recommend that the Department of Health Services provide the Legislature a report in time for hearings on the fiscal year 1980-81 budget. The report should include this information:

1. A plan for increasing staffing of the hospital audit function. This plan should include potential efficiencies, coordination with audit units in other agencies, and redirection of staff within the department. The plan should also detail information on staffing costs and projected recoveries, and should meet minimum federal auditing requirements for hospitals.

2. Alternative staffing levels for other components of the overpayment identification and recovery system. This segment should include staffing costs as well as the effects of these levels on case backlogs, the length of time to complete a case, and the potential for increasing recoveries.

3. Any options the department has considered or is considering for funding its system components.

MATTERS FOR CONSIDERATION BY THE LEGISLATURE

As previously discussed, the Federal Government currently funds 90 percent of the operating costs of the Department of Justice Medi-Cal Fraud Unit. We compared the staffing levels and responsibilities of the two largest Medicaid programs, those of New York and California. New York's unit recovers more money, investigates a broader scope of fraudulent activity, and develops alternative sources of cases. Given the minimum outlay of state funds required, the Legislature may wish to consider increasing the staffing level of the Department of Justice Medi-Cal Fraud Unit.*

New York and California have approximately the same Medicaid expenditures. Yet New York employs more professional staff than does California. The differences in staffing levels exist, in part, because New York's nursing home payment system necessitates a higher level of investigation and audit by New York's MCFU. However, as shown in Table 8 below, New York's staffing is substantially greater than is California's, even after staff allocated to nursing home investigations and audits are subtracted.

* The 1980-81 Governor's Budget proposes a 34-position increase for the MCFU.

TABLE 8

PROGRAM SIZE AND RESOURCES
OF CALIFORNIA AND NEW YORK MCFUs
FISCAL YEAR 1978-79

	California	New York
Volume of Medicaid Program	$3.33 billion	$3.62 billion
Number of Health Care Facilities	2,200	2,062
Number of Professional Providers	47,800	22,419
MCFU Professional Staff		
Lawyers	5	12
Investigators	30	36
Auditors	4	31
Total Staff	39	79
Total Overpayments Identified by MCFU*	$178,959	$1,468,073

New York's MCFU has a broader scope of investigative activity, which includes nursing homes, hospitals, ambulatory care, patient abuse, and civil recovery. California's MCFU activity is restricted primarily to hospitals and ambulatory care.

* The New York MCFU has been in operation longer than California's unit. As a result, overpayment statistics provided by New York may reflect some cases developed in conjunction with prior work.

California's sources of cases also differ from those of New York. California's MCFU receives all its case referrals from the DHS Investigations Branch and has a substantial case backlog. New York's unit, on the other hand, invests most of its resources in developing its own cases because management believes case referrals from New York's Department of Social Services (DSS) are usually too old to prosecute successfully. Those referrals it does receive are returned to DSS after 30 days if no action has been taken.

Ninety percent federal funding affords the Medi-Cal program an opportunity to increase its provider fraud effort at a minimal cost to the State. The Legislature's authorization of more staff could allow the MCFU to reduce its backlog of cases, expand its scope of investigations, and develop its own case referrals.

Respectfully submitted,

Thomas W. Hayes

THOMAS W. HAYES
Auditor General

Date: February 22, 1980

Staff: Richard C. Mahan, Audit Manager
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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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February 19, 1980

Thomas W. Hayes
Auditor General
925 L Street, Suite 750
Sacramento CA 95814

Dear Mr. Hayes:

"THE IMPACT OF STAFFING SHORTAGES ON THE IDENTIFICATION AND RECOVERY OF MEDI-CAL OVERPAYMENTS"

Thank you for sharing a draft of the above mentioned report with the Department.

Overall the report seems to accurately portray the impact of staffing shortages and we are in general agreement with the conclusions and recommendations contained in the draft.

In specific terms the Department agrees with the report recommendation that we provide to the Legislature a report in time for use in the 80-81 budget hearings. The information called for will contribute to a productive budget process, and in any event, would be part of a full discussion of the request in the Governor's proposed budget for an additional 18 positions in the Investigations Branch of the Audits and Investigations Division.

Thank you for the opportunity to comment. The lack of the usual "technical detail corrections" which are often necessary in responses to reports is a positive measure of the quality of work done by your staff in the field.

Sincerely,

Barry S. Dorfman

Barry S. Dorfman, M.D.
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Program Integrity

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February 15, 1980

Mr. Thomas W. Hayes
Auditor General
925 L Street, Suite 750
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Dear Mr. Hayes:

Thank you for providing us with a draft copy of your report, "The Impact of Staffing Shortages on the Identification and Recovery of Medi-Cal Overpayments." It is apparent that you have invested considerable time and effort in identifying the causal factors in the failure of the state to adequately protect the taxpayers' interests in recovery of Medi-Cal overpayments. Your work and that of your staff has been thorough and generally accurate.

Only one major inaccuracy has been noted. Table 8 at page 40 is extremely misleading insofar as it attempts to compare the FY 1978-79 overpayments identified by the New York and California MCFUs. In order to make an entirely accurate comparison, the overpayment figure for New York should be $7,000. It is a well known fact that cases involving massive fraud and complex conspiracies take years rather than months to investigate and prosecute. The California Medi-Cal Fraud Unit has not been in existence for years. In fact, it became fully staffed 15 months ago in October 1978, at which time we began training our new staff as criminal investigators.

According to Jean Jaswinski of the New York MCFU, the New York $684,640 figure represents two cases. One involved one defendant and a $7,000 overpayment; the other involved three defendants and a $679,640 overpayment. Investigation on the larger case began in May 1975. Ms. Jaswinski said "It took us four years to prove what we found out in the first year."

Only the $7,000 New York case represents an overpayment identified within the comparative period of existence of the Medi-Cal Fraud Unit. In October 1982, when California's Medi-Cal Fraud Unit shall have had an equivalent case development time, the identified overpayment in California for FY 1982-83 can accurately be compared to New York's $684,640.*

* In response to this exception, overpayment statistics presented in Table 8 on page 40 were modified to reflect only overpayments identified during fiscal year 1978-79 rather than overpayments recovered.

There is another factor not reflected in the comparison of California and New York identified overpayments for FY 1978-79 which skews the result. The staffing figures for California fail to take into consideration that one-seventh of the available investigator manhours for the entire fiscal year statewide were invested in one large scale investigation which is not yet reflected in total overpayments identified.

Following are some general comments regarding the draft report.

At page 6 you state that the Department of Health Services Investigations Branch conducts preliminary investigations in provider cases. This is not in fact true. It was the intent of the Congress in making federal funding available to Medicaid fraud units that the single state agency (in California the Department of Health Services) would conduct preliminary investigations of alleged provider fraud. However, from the very outset this has not happened. The reductions in staffing in the Health Investigations Branch which occurred simultaneously with the establishment of the Medi-Cal Fraud Unit (see your Table 1 at page 14) made it difficult for the Investigations Branch to perform this function. As a result, preliminary investigations are conducted by the Medi-Cal Fraud Unit. This has imposed an additional workload burden on the unit which was not planned for when the initial 94.2 positions were requested.*

At page 11 you note that as a result of inadequate staffing the Medi-Cal Fraud Unit is not investigating all providers who may be perpetrating fraud. This is true. However, it should not be suggested that every case of a technical criminal violation should be investigated. Even under ideal staffing conditions, there will be instances in which the amount of possible criminal fraud is so small, or in which the likelihood of a jury finding the provider-defendant guilty is so small, that it is not economically feasible to investigate the case. In other words, not all cases of technical Medi-Cal fraud should be worked.

At page 14 your Table 1 reveals a decrease of total investigation staffing from 114.0 in FY 1977-78 to a total of 97.5 (combined Investigations Branch and MCFU) in FY 1979-80. Implicit in the staffing data is an assumption that, but for, the decrease of 16.5 positions from the 1977-78 level there would be no problem. Or, conversely, had the total number of positions remained at the 1977-78 level, the Medi-Cal provider fraud investigation function would be properly staffed. Such an assumption, however, overlooks the initial fact that Congress made 90% federal funding available to states to increase their anti-fraud efforts. The funding was not made available in order that states could merely transfer the function from one bureaucratic agency to another.

* See footnote on page 45.

At page 29 you indicate that the Investigations Branch performs the preliminary investigation of provider fraud complaints and then refers these cases to the Medi-Cal Fraud Unit. As indicated above, it was the original intent of Congress and the Department of Health, Education, and Welfare that the single state agency perform this function, and our initial request for staffing for the Medi-Cal Fraud Unit was based upon this assumption. However, no preliminary investigations of provider fraud cases are conducted by the Investigations Branch. Similarly, at page 30 the first sentence should indicate that the preliminary investigations referred to are of beneficiary and non-criminal provider fraud only. Similarly, Table 4 is inaccurate insofar as the 3,693 provider preliminary investigations opened may include any criminal preliminary investigations. At page 31 Table 5 should indicate whether or not the 1978-79 provider preliminary investigations are limited to civil and administrative cases only.*

At page 31 you indicate that Investigations Branch management is placing a priority on fraud by Medi-Cal beneficiaries, as opposed to provider fraud. This no doubt explains what we have observed in the referrals received in the Medi-Cal Fraud Unit. During the most recent 3-month period (November and December 1979, and January 1980) Investigations Branch has referred a total of 5 cases statewide to the Medi-Cal Fraud Unit. Of these 5 cases, two were classified in the MCFU as either a III or IV, and returned to DHS immediately.

We are pleased that you have undertaken this series of analyses. It is apparent that the Medi-Cal overpayment situation is in need of such scrutiny. If I or any member of our staff can be of assistance to you in any regard, please let us know.

Sincerely yours,

George Deukmejian,
Attorney General

Marjory Winston Parker
Assistant Attorney General
Chief, Medi-Cal Fraud Unit

MWP:er

* Auditor General's Comment: The Department of Health Services and the Attorney General's Medi-Cal Fraud Unit each interpret differently the definition of and responsibility for a preliminary investigation. Our discussion of responsibilities and activities of the Investigations Branch is based upon definitions used by the Department of Health Services.

ASSUMPTIONS AND METHODOLOGY USED TO CALCULATE OPPORTUNITY COSTS

This section presents the assumptions and methodology we used in calculating the opportunity cost associated with Audits Branch staffing reductions.

Assumptions

To calculate the opportunity cost, we made these assumptions:

1. Despite staffing cuts, the Audits Branch would continue to conduct field audits of hospitals with high levels of Medi-Cal participation.

2. The Audits Branch would continue to perform field audits of hospital home offices (corporate headquarters) despite staffing cuts.

3. Fiscal year 1978-79 represents a typical audit year for both fiscal and multidisciplinary audits.

4. The number of hospitals in the State and their level of Medi-Cal participation remain reasonably constant.

5. The hospitals' level of Medi-Cal participation is the governing criterion in selecting field versus desk audits.

6. The 14 auditor positions cut would have been used to conduct field audits of hospitals.

Methodology

Based on the above assumptions, we applied the following methodology:

Conventional Audits

1. To allow for the substitution of desk audits for field audits, we identified the average net difference between field and desk audit net recoveries at levels of hospital participation between $0 and $1.5 million. This category was selected for the following reasons:

   - Hospitals in this category account for two-thirds of all hospitals participating in Medi-Cal;

- Over half the field audits performed in fiscal year 1978-79 were of hospitals in this category;

- The Audits Branch's criterion of 75 percent field and 25 percent desk audits, based primarily on hospitals' level of Medi-Cal participation dictates that field audits be performed for hospitals with levels of participation as low as $.3 million to $.4 million.

The net difference calculation included deductions for administrative overhead and disallowances for two levels of administrative appeal.

2. Next, we identified hospital cost reports which the branch would normally review during field audits if staff were available. These reports were from hospitals with a participation level of $1.5 million or less.

3. Using the average number of hours required to field audit hospitals with incremental levels of Medi-Cal participation between $0 and $1.5 million, we allocated the total hours available for the 14 field auditor positions to the hospitals, beginning with the highest and progressing to the lowest levels of participation until the available hours were exhausted.

4. We next multiplied the number of hospitals in each incremental level by the average field audit/desk audit net difference and added the resultant figures to determine a preliminary opportunity cost.

5. Because an equal number of hospital cost reports would have to be accepted as filed without desk audit if desk audits were to be substituted for the field audits, we added an amount equal to the net desk audit recovery for the hospitals with the lowest level of Medi-Cal participation (i.e., which would normally be desk audited) multiplied by the number of cost reports we determined could have been field audited. We added this amount to the preliminary opportunity cost to determine the net opportunity cost.

Multidisciplinary Audits

1.	To compute the opportunity cost associated with the reduction of multidisciplinary audit staffing by 13 field team members, we identified the total audit adjustments made by multidisciplinary audit during fiscal year 1978-79.*	$10,300,000
2.	We then reduced the audit adjustments by $576,800, the estimated value of disallowances through first level appeal.** This estimate is proportionate to the first level disallowances made for the five multidisciplinary audits conducted in fiscal year 1977-78, the first year of multidisciplinary audits. Exceptions through first level appeal thus became	$ 9,723,200
3.	Next, we subtracted all administrative overhead costs associated with multidisciplinary audits in fiscal year 1978-79. These costs amounted to $1,338,093. The net return through first level appeal thus became	$ 8,385,107
4.	We then computed a net return per field staff member, as follows:	
	- Net return through first level appeal	$ 8,385,107
	- Divided by number of full time equivalent field staff available in fiscal year 1978-79	24.6
	- Net return per field staff member	$ 340,858

* Not all audit reports were final; accordingly, this is an estimate from the Chief of the Audits Branch.

** Only first level appeal data was available. This amounted to a 5.6 percent reduction factor. No second level decisions had been issued by the time this report went to print.

5. Finally, we estimated the opportunity cost associated with the 13 position reduction:

- Number of field staff positions cut	13
- Multiplied by the net return per field staff member	$ 340,858
- Opportunity cost	$ 4,431,154

Multidisciplinary audits are a unique means of auditing hospitals. There is no field or desk audit counterpart to the medical review portion of a multidisciplinary audit. Therefore, we did not offset the opportunity cost with estimates of recoveries from field or desk audits.

The opportunity cost associated with the multidisciplinary audits is through first level appeal only. An indeterminable amount of disallowances would also occur in second level appeal. Therefore, our estimate of the multidisciplinary audit opportunity cost must be qualified.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
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